County of Los Angeles
CHIEF EXECUTIVE OFFICE
713 KENNETH HAHN HALL OF ADMINISTRATION
LOS ANGELES, CALIFORNIA 90012
(213) 974-1101
http://ceo.lacounty.gov

DAVID E. JANSSEN
Chief Executive Officer

July 10, 2007

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

APPROVAL OF TRAUMA CENTER SERVICE AUGMENTATION AGREEMENT AMENDMENT WITH ST. FRANCIS MEDICAL CENTER
(2nd District) (3 Votes)

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve and instruct the Director of Health Services, or his designee, to offer and sign the Trauma Center Service Augmentation Agreement (TCSAA) Amendment No. 3, substantially similar to Exhibit I, with St. Francis Medical Center (SFMC), effective upon Board approval through November 30, 2007, for a total maximum amount of approximately $0.3 million.

2. Delegated authority to the Director of Health Services, or his designee, to extend the Agreement for one year through November 30, 2008 at the written request of SFMC, unless the County objects for good cause, upon substantially similar terms and conditions, with review and approval by County Counsel and the Chief Executive Office.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

The purpose of the recommended action is to approve TCSAA Amendment No. 3 which will provide for the same payment rates to SFMC physicians who provide TCSAA services to eligible indigent patients as the payment rates they receive for performing services at SFMC under the MetroCare Plan for patients transferred from Martin Luther King, Jr.-Harbor Hospital (MLK-Harbor) and the surrounding County outpatient clinics, up to a maximum length of inpatient stay of six days per admission.

FISCAL IMPACT/FINANCING

The maximum obligation for this Amendment with SFMC, from Board approval through November 30, 2007 is $0.3 million. The maximum obligation for the potential one-year extension is $0.7 million for a total maximum obligation of $1.0 million.

St Francis_bl

Funding for the increase in physician payments is included in the Department of Health Services' Fiscal Year (FY) 2007-08 Adopted Budget, under the MetroCare Plan (within the MLK-Harbor budget), and will be requested in future fiscal years, as required.

The Amendment provides for payment to SFMC physicians at the same rate of payment they receive under the MetroCare Plan, i.e.,100 percent of the Medicare allowable Area 18 fee schedule, to include patient copayment amount of twenty percent (20 percent), not to exceed billed charges, for a maximum length of inpatient stay of six (6) days. This amount is higher than the existing TCSAA amount.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

On February 22, 2005, the Board approved the TCSAA with SFMC to provide funding for increased emergency services, particularly trauma services, at SFMC as a result of the closure of Martin Luther King, Jr./Drew Medical Center's trauma services.

On January 30, 2007, the Board approved Amendment No. 2 for TCSAA services with SFMC which increased the hospital rate paid to SFMC for a limited number of transitional capacity patients. Transitional capacity patients are eligible indigent patients including 1) patients who have been redirected to SFMC from MLK-Harbor's service area and, 2) emergency room patients from MLK-Harbor's catchment area. TCSAA patients arrive at SFMC via paramedic ambulance or are walk-in patients admitted directly from the SFMC emergency room.

The January 30, 2007 increased hospital rate reflected the need for SFMC to maintain adequate capacity and was consistent with the rate paid to SFMC under its MetroCare Agreement. The SFMC MetroCare Agreement covers patients who are first treated at the MLK-Harbor emergency room and subsequently referred by MLK-Harbor to SFMC for admission. The changes made under the January 30, 2007 TCSAA Amendment No. 2 were made to provide payment to SFMC, for a limited number of other indigent patients, that was consistent with the MetroCare Agreement.

This TCSAA Amendment No. 3 provides for payment consistency with the MetroCare Agreement for SFMC physicians. The increased amount to be paid to SFMC physicians to achieve this consistency shall be limited to the total amount allocated by the Board on November 28, 2006 for private hospitals and physicians under the MetroCare Plan, i.e., $85 million.

County Counsel has approved the attached Agreement, Exhibit I, as to form.

Attachment A provides additional information.

CONTRACTING PROCESS

SFMC is a current participant in the County's trauma system and satisfies the State and County criteria and conditions for such participation.

An open competitive solicitation process was not conducted because the purpose of the TCSAA is specifically to reimburse St. Francis for increased patient volume as a result of the closure of Martin Luther King, Jr./Drew Medical Center's trauma center in 2005.

Payment to physicians providing medical services to TCSAA patients is through Physician Services for Indigents Program (PSIP)-MetroCare. Any non-County physician providing TCSAA services to indigent patients at SFMC is eligible to participate in the PSIP-MetroCare by completing the FY 2006-07 Conditions of Participation Agreement and the Enrollment Form and by following the policies and procedures included in Attachment "B-5" of the Amendment (attached for reference).

It is not appropriate to advertise this Amendment on the Office of Small Business' Countywide Web Site.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of this Amendment No. 3 will ensure the current level of augmented transitional capacity services at SFMC is maintained.

CONCLUSION

When approved, the Department of Health Services requires three signed copies of the Board's action.

Respectfully submitted,

DAVID E. JANSSEN
Chief Executive Officer

DEJ:SRH:SS
DJ:LT:bjs

Attachments (2)

c: County Counsel
Director and Chief Medical Officer, Department of Health Services
Chair, Emergency Medical Services Commission
Hospital Association of Southern California

St Francis_bl

ATTACHMENT A

SUMMARY OF BOARD LETTER

1. Type of Service:

   Trauma Center Service Augmentation Physician Services at St. Francis Medical Center

2. Address and Contact Person:

   St. Francis Medical Center
   3630 East Imperial Highway
   Lynwood, CA 90262
   Attention: Gerald T. Kozai, President/Chief Executive Officer
   Telephone: (310) 537-724
   Fax: (310) 900-7324

3. Term:

   Effective upon Board approval through November 30, 2007, with an option to extend one additional year through November 30, 2008.

4. Financial Information:

   The estimated annual cost for the increase in Trauma Center Service Augmentation Physician Services is $0.3 million through November 30, 2007, and $0.7 million from December 1, 2007 through November 30, 2008. The estimated additional total cost through November 30, 2008 is $1.0 million.

5. Accountable for Program Monitoring:

   The County's local EMS Agency, i.e., the Department of Health Services' EMS Division.

6. Primary Geographic Area to be Served:

   2nd District

7. Approvals:

   EMS: Cathy Chidester, Acting Director

   Contracts and Grants Division: Cara O'Neill, Chief

   County Counsel (approval as to form): Edward A. Morrissey, Deputy County Counsel

   CAO Budget Unit: Latisha Thompson

EXHIBIT I

Contract # H-700906-3

TRAUMA CENTER SERVICE
AUGMENTATION AGREEMENT

AMENDMENT NO. 3

THIS AMENDMENT is made and entered into this _____ day of _____, 2007,

by and between COUNTY OF LOS ANGELES (hereafter "County"),

and ST. FRANCIS MEDICAL CENTER (hereafter "Contractor")

WHEREAS, reference is made to that certain document entitled "TRAUMA CENTER SERVICE AUGMENTATION AGREEMENT", dated March 1, 2005, and further identified as County Agreement No. H-700906, and any Amendments hereto (all hereafter referred to as "Agreement"); and

WHEREAS, the parties hereto have previously entered into a written agreement entitled "TRAUMA CENTER SERVICE AGREEMENT", dated June 24, 2003, superseded by a replacement agreement dated July 1, 2006, and further identified as County Agreement No.H-702651, and any Amendments hereto; and

WHEREAS, the parties wish to increase the payment to Physicians providing medical services under this Agreement to one hundred percent (100%) of the Medicare Area 18 allowable fee schedule for physician reimbursement, to include patient

copayment of twenty percent (20%), not to exceed billed charges; and

WHEREAS, the parties wish to increase and limit payment for the number of inpatient days that Physicians providing services under this Agreement may receive up to a maximum of six (6) inpatient days per admission; and

WHEREAS, Agreement provides that changes may be made in the form of a written amendment which is formally approved and executed by the parties; and

NOW, THEREFORE, the parties agree as follows:

1. Paragraph 2, STANDARD TERMS AND CONDITIONS, of Agreement shall be deleted in its entirety and replaced with the following:

"2. STANDARD TERMS AND CONDITIONS: Except as set forth in this Agreement, and except for sections 1.A, 12, 13, and 14, and Exhibits A, C, D, and E, and sections I.D., II, III, and subsection E "BILLING AND PAYMENT - PHYSICIAN SERVICES", of section I."ELIGIBLE INDIGENT CARE FUNDING", and Attachments B-1 and B-5, and U-1 of Exhibit B "PROVISIONS FOR REIMBURSEMENT", the parties agree that all other terms and conditions as set forth in the provisions of County Agreement No.H-702651, any Amendments, and any Exhibits and Attachments thereto, shall be incorporated herein by reference. Contractor hereby acknowledges that it shall adhere to all such terms and conditions under this

Agreement."

2. REPLACEMENT/ADDITIONAL TRAUMA AUGMENTATION TERMS: In addition to, or as a replacement to, the terms and conditions set forth in County Agreement H-702651 and any amendments, exhibits, and attachments thereto, the parties agree to the following provisions:

A. Subparagraph E "BILLING AND PAYMENT - PHYSICIAN SERVICES" of Paragraph I. "ELIGIBLE INDIGENT CARE FUNDING", of Exhibit B "PROVISIONS FOR REIMBURSEMENT", of Agreement shall be revised and replaced to read as follows:

"E. A copy of the Physician Services For Indigents Program - MetroCare packet, effective upon Board of Supervisors' approval through November 30, 2007,or upon expiration of this Agreement, whichever is later, Attachment "B-5", is attached and incorporated herein by reference. The packet for future years shall be provided to Contractor as soon as available thereafter. To permit its physicians to bill County for the professional component of unreimbursed augmentation services furnished to Contractor's patients during the term of this Agreement, Contractor shall furnish members of its physician staff providing such services with a copy of said packet. County payment to physicians for such unreimbursed augmentation inpatient services shall be limited to

a maximum of six (6) inpatient days per admission.

Upon request, Director shall provide Contractor with reports showing total aggregate payments to augmentation physicians reimbursed by County for the professional component of unreimbursed augmentation services provided to Contractor during the term of this Agreement.

B. Attachment B-5 of Agreement is replaced with revised Attachment B-5, attached hereto and incorporated therein.

C. Subparagraph C. INCREASED FUNDING FOR PHYSICIAN SERVICES is added to Paragraph 5. REPLACEMENT FUNDING, as follows:

"C. INCREASED FUNDING FOR PHYSICIAN SERVICES: The parties agree and understand that County funding for the increased amount to be paid to Physicians performing services at Contractor's Medical Center under this Amendment shall be limited to $0.3 million for the period of upon Board approval through November 30, 2007, plus $0.7 million for the period of December 1, 2007 through November 30, 2008, for a total Amendment amount of $1.0 million."

3. Except for the changes set forth hereinabove, the wording of Agreement shall not be changed in any respect by this Amendment.

IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Agreement to be subscribed by its

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

Director of Health Services and Contractor has caused this Agreement to be subscribed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By _____
Bruce A. Chernof, M.D.
Director and Chief Medical Officer

ST. FRANCIS MEDICAL CENTER
Contractor

By _____
Signature

_____
Printed Name

_____
Title

_____
Date

(AFFIX CORPORATE SEAL HERE)

APPROVED AS TO FORM
BY THE OFFICE OF THE COUNTY COUNSEL

APPROVED AS TO CONTRACT
ADMINISTRATION:

Department of Health Services

By_____
Cara O'Neill, Chief
Contracts and Grants Division

ATTACHMENT B-5

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

PHYSICIAN REIMBURSEMENT PROGRAM

PROGRAM ENROLLMENT PROVIDER FORM FISCAL YEAR 2006/07

Completion of Enrollment Form is required annually by each physician

Physician Name: _____
(Last Name) (First Name) (M.I.)

Address: _____ City: _____ Zip Code: _____

Telephone No.: (____) _____ Contact Person: _____

E-mail Address: _____

Primary Specialty: _____ State License Number: _____

U.P.I.N.: _____ Payee Tax I.D.#: _____

Payee Address: _____ City: _____ State: _____ Zip Code _____

Physician/Group name must match IRS Tax ID Number

IF PAYEE IS A PHYSICIAN GROUP, COMPLETE GROUP INFORMATION BELOW:

Group Name: _____

IF USING A BILLING COMPANY, COMPLETE BILLING COMPANY INFORMATION BELOW:

Company Name: _____ E Mail Address: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number: ( ) _____ Contact Person: _____

LIST ALL HOSPITALS WHERE MEDICAL SERVICES ARE PROVIDED WITHIN LOS ANGELES COUNTY

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

If information on this form changes in any way, a new provider application must be submitted with the corrected information. This application must be completed by each physician providing services claimed under this program.

As a condition of claiming reimbursement under the Physician Services for Indigents program and/or the Trauma Physician Services Program, I certify that the above information is true, and complete to the best of my knowledge.

_____ _____
SIGNATURE OF PHYSICIAN DATE

IMPORTANT: For prompt processing, return this form as soon as possible to:

AMERICAN INSURANCE ADMINISTRATORS
P.O. BOX 2340
Bassett, CA 91746-0340

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

PHYSICIAN SERVICES FOR INDIGENTS PROGRAM -- **METROCARE**

EFFECTIVE UPON BOARD OF SUPERVISORS' APPROVAL – **NOVEMBER 30, 2007**
CONDITIONS OF PARTICIPATION AGREEMENT

SUBMIT TO: AMERICAN INSURANCE ADMINISTRATORS (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340

The undersigned physician (hereinafter "Physician") certifies that claims submitted hereunder are for emergency, inpatient, and/or limited outpatient (one [1] followup visit) services provided by him/her to patients who do not have health insurance coverage for such care, and who cannot afford to pay for services rendered, and for whom payment will not be made through any private coverage or by any program funded in whole by the federal government.

Physician acknowledges receipt of a copy of the "Physician Services for Indigents Program -- Metrocare (PSIP-M) Billing Procedures" (hereinafter "Billing Procedures"), promulgated by the County of Los Angeles, Department of Health Services, effective upon Board of Supervisors' approval through November 30, 2007.

Physician certifies that claims for emergency, inpatient, and/or limited outpatient (one [1] followup visit) services shall only be submitted for patients transferred to or treated at a contracted non-County hospital for indigent services and have a Medical Alert Center transfer authorization number which shall be provided as part of the HCFA-1500.

Physician agrees that all obligations and conditions stated in the Billing Procedures will be observed by him/her, including, but not limited to, the proper refunding of monies to the County when patient or third-party payments are made after reimbursement under this claiming process has been received; the cessation of current, and waiver of future, collection efforts from the patient upon receipt of payment by County; and the preparation, maintenance, and retention of service and finance records, including their availability for audit. Physician affirms that for all claims submitted, reasonable efforts to identify third-party payers have been made, no third-party payers have been discovered, and no payment has been received.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor for reimbursement as a result of care and services provided by Physician, and/or his/her staff, upon payment by County under the PSIP-M. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law regardless of the amount the Physician has received under the PSIP-M (e.g., physician's full billed charges). Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

Physician expressly acknowledges and accepts that any County liability for claims submitted hereunder is at all times subject to conditions defined in the Billing Requirements, including, but not limited to, (1) availability of monies in the PSIP-M, (2) priority of claim receipt, and (3) audit and adjustments. In accordance with instructions in the Billing Procedures, Physician agrees to submit required documents for claims, and provide other patient data as may be required by the County.

Physician certifies that information on claims submitted by him/her is true, accurate, and complete to the best of his/her knowledge.

TYPED/PRINTED NAME OF PHYSICIAN	TAX ID NUMBER
PRIMARY SPECIALTY OF PHYSICIAN	SIGNATURE OF PHYSICIAN
STATE LICENSE NUMBER	DATE

COUNTY OF LOS ANGELES ● DEPARTMENT OF HEALTH SERVICES

PHYSICIAN SERVICES FOR INDIGENTS PROGRAM – METROCARE ST. VINCENT and ST. FRANCIS MEDICAL CENTER

BILLING PROCEDURES

Effective Upon Board of Supervisors' Approval Through November 30, 2007

I. INTRODUCTION

Pursuant to existing contracts with non-County hospitals for indigent services for MetroCare, a Physician Services for Indigents Program-METROCARE ("PSIP-M") has been established by the County of Los Angeles ("County") to provide reimbursement to private physicians ("Physician") for certain professional services that have been rendered in Los Angeles County to eligible indigent patients. Professional physician services herein referred to are limited to emergency, inpatient, and/or limited outpatient (one [1] followup visit) services.

Professional physician services which can be reimbursed under this claiming process are additionally restricted as prescribed by the County, with such restrictions subject to revision from time to time. Current County physician reimbursement restrictions are set forth in "Department of Health Services Physician Reimbursement Policies for MetroCare, effective upon Board approval through November 30, 2007" attached as Exhibit "B-5" hereto and incorporated herein by reference. The County has discretion to revise such policies from time to time as deemed necessary or appropriate and if approved by the Board of Supervisors.

In no event may this claiming process be used by Physician if his/her services are included in whole or in part in hospital or physician services claimed by a hospital or by Physician under a separate formal contract with County.

This document defines the procedures which must be followed by Physician in seeking reimbursement under this Program. Submission of a claim by Physician under these procedures establishes (1) a contractual relationship between the County and Physician covering the services provided and (2) signifies Physician's acceptance of all terms and conditions herein.

These claiming procedures are effective from Board approval through November 30, 2007 pursuant to the Trauma Center Service Augmentation Agreement; are only valid for covered services to the extent that monies are available therefor in accordance with maximum amount approved by the Board of Supervisors for the MetroCare Program on November 28, 2006 less payments to participant's contract hospitals, unless further funds are made available upon future approval by the Board; and are subject to revisions as required by State laws and regulations and County

requirements. This claiming process may not be used by a physician if he or she is an employee of a County hospital while performing the services.

II. PHYSICIAN ELIGIBILITY

A. Physician must complete a current fiscal year Physician Services for Indigents Program--MetroCare "Conditions of Participation Agreement" and "Program Enrollment Provider Form" and provide them to the County's contracted Claims Adjudicator (see address on page 4).

B. Physicians who provide emergency, inpatient, and/or limited outpatient (one [1] followup visit) services to eligible patients in a Los Angeles County acute care hospital with a MetroCare Inpatient Program Agreement, may submit a claim hereunder.

C. Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation to the extent the physician is authorized to bill for such services and payment for such services will not be made to any hospital participants in the MetroCare Program where such services were rendered. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician assistants in California.

D. An emergency physician and surgeon or an emergency physician group with a gross billings arrangement with a hospital located in Los Angeles County shall be entitled to receive reimbursement for services provided in that hospital, if all of the following conditions are met:

1. The services are provided in a basic or comprehensive general acute care hospital emergency department.

2. The physician and surgeon is not an employee of the hospital.

3. All provisions of Section III of these Billing Procedures are satisfied, except that payment to the emergency physician and surgeon, or an emergency physician group, by a hospital pursuant to a gross billings arrangement shall not be interpreted to mean that payment for a patient is made by a responsible third party.

4. Reimbursement is sought by the hospital or the hospital's designee, as the billing and collection agent for the emergency physician and surgeon or an emergency physician group.

For the purposes of this section, a "gross billings arrangement" is an arrangement whereby a hospital serves as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group, and pays a percentage of the emergency physician and surgeon's or group's billings for all patients.

III. PATIENT ELIGIBILITY/BILLING EFFORTS

Patients covered by this claiming process are only those who do not have health insurance coverage for emergency, inpatient, and/or limited outpatient (one [1] followup visit) services, and who cannot afford to pay for services rendered, and for whom payment will not be made through any private coverage or by any program funded in whole by the federal government, including Full Scope Medi-Cal. Claims for patients with Limited Scope Medi-Cal will be restricted to services not covered by Medi-Cal.

During the time prior to submission of the bill to the County, Physician must have made reasonable efforts to obtain reimbursement and not received payment for any portion of the amount billed. For purposes of this claiming process, reimbursement for unpaid physician billings shall be limited to the following:

(a) patients for whom Physician has conducted reasonable inquiry with the hospital to determine if there is a responsible private or public third-party source of payment (e.g., application for coverage under Medi-Cal and/or Medicare, when appropriate), and

(b) patients for whom Physician has billed all possible payment sources, but has not received full reimbursement.

Upon receipt of payment from the County under this claiming process, Physician must cease any current, and waive any future, collection efforts to obtain reimbursement from the patient.

If, after receiving payment from the County hereunder, Physician is reimbursed by a patient or a responsible third party, Physician shall immediately notify the County (see address below) in writing of the payment, and reimburse the County the amount received from the County.

MAKE REFUND CHECK PAYABLE TO:
County of Los Angeles/Department of Health Services
Refund checks should be accompanied by:
-- a copy of the Remittance Advice, and
-- a specific explanation for the refund, e.g., received payment for services from Medi-Cal, etc.

SUBMIT NOTIFICATION AND/OR REFUND TO:
County of Los Angeles/Department of Health Services
Fiscal Services – MetroCare Program
313 North Figueroa Street, Room 505
Los Angeles, CA 90012

IV. CONDITIONS OF REIMBURSEMENT

Payment is contingent upon adherence to State law and County requirements regarding eligible claims, and provision of data as specified in these Billing Procedures.

V. CLAIM PERIOD

Claims may only be submitted for eligible services provided on/or after Board of Supervisors' approval through November 30, 2007 pursuant to the MetroCare agreements with associated hospitals. All claims for services provided during this period must be received by County's Claim Adjudicator no later than March 31, 2008. Claims received after this deadline has passed will not be paid. Unless sooner terminated, canceled, or amended, this claim process shall expire on March 31, 2008.

VI. REIMBURSEMENT

Payment of a valid claim hereunder will be limited to a maximum of 100% of Medicare allowable Area 18 fee schedule to include patient copayment amount of twenty percent (20%), not to exceed billed charges. The MetroCare Fee Schedule utilizes the most current Physicians' Current Procedural Terminology (CPT-4) codes in conjunction with the Resource Based Relative Value Scale (RBRVS) unit values in affect on the date of admission.

VII. COMPLETION OF FORMS

A. Complete "Effective upon Board of Supervisors' Approval – November 30, 2007 Conditions of Participation Agreement" for the current fiscal year Physician Services for Indigents Program – METROCARE (sample attached). Submit one original signed Agreement to the contracted Claims Adjudicator:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340

B. Complete one HFCA-1500 Form per patient including the following:

1. Medical Alert Center (MAC) Authorization number in Section 11, INSURED'S POLICY GROUP OR FECA NUMBER, and

2. The term "METROCARE" in Section 11c, INSURANCE PLAN NAME OR PROGRAM.

ELECTRONIC BILLING

As an option, the County's Claims Adjudicator can receive claims electronically. The record layout necessary for electronic submission shall be obtained directly from the County Claims Adjudicator at (800) 303-5242.

IX. SUBMIT CLAIM(S) TO COUNTY'S CONTRACTED CLAIMS ADJUDICATOR

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
ATTN: METROCARE

X. CLAIM REJECTION AND APPEALS

A. Revised claims previously rejected for incomplete information must be received by the contracted Claims Adjudicator within 20 calendar days from the date of the rejection letter.

B. The Physician must submit an appeal of any denied claim within thirty (30) calendar days from the date of the denied Remittance Advice. A denied claim can be appealed once; however, after the appeal is dispositioned, a further appeal will not be considered. All appeals shall be prepared and sent in accordance with the directions set forth in Exhibit "A".

XI. INFORMATION CONTACTS

For Status of Claims, call:
AIA Physician Hotline - (800) 303-5242

For Program/Policy Issues, call:
Emergency Medical Services Agency
EMS Reimbursement Coordinator
(323) 890-7521

XII. COUNTY LIABILITY/PAYMENT/SUBROGATION

Payment of any claim under this claiming process is expressly contingent upon the availability of monies set forth herein, and allocated therefor by the County of Los Angeles Board of Supervisors. To the extent such monies are available for expenditure under the Physician Services for Indigents Program - MetroCare, and until such available monies are exhausted, valid claims may be paid. Valid claims will

be paid in the order of receipt; that is, if a complete and correct claim is received by County, it will have priority over claims subsequently received.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor for reimbursement as a result of care and services provided by Physician, and/or his/her staff, upon payment by County under the PSIP-M. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law regardless of the amount the Physician has received under the PSIP-M. Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

XIII. GENERAL OBLIGATION OF PHYSICIANS SUBMITTING CLAIMS

In addition to any Physician duties specified previously herein, Physicians using this claiming process are obligated as follows:

A. Records/Audit Adjustment

1. Physician shall immediately prepare, and thereafter maintain, complete and accurate records sufficient to fully and accurately reflect the services provided, the costs thereof, all collection attempts from the patient and third-party payers, and revenue collected, if any, for which claim has been made under this claiming process.

2. All such records shall be retained by Physician at a location in Los Angeles County for a minimum of three (3) years following the last date of the Physician services to the patient.

3. Such records shall be made available during normal County working hours to representatives of the County and/or State, upon request, at all reasonable times during such three year period for the purposes of inspection, audit, and copying. Photocopying capability must be made available to County representatives during an on-site audit.

4. County may periodically conduct an audit of the Physician's records. Audits shall be performed in accordance with generally accepted auditing standards. The audit may be conducted on a single claim, a group of claims, or a statistically random sample of claims from the adjudicated universe for a fiscal year. The scope of the audit shall include an examination of patient medical and financial records, patient/insurance billing records, and collections agency reports associated with the sampled claims.

   Audited claims that do not comply with program requirements shall result in a refund to the County. If the audit was conducted on a statistically random sample of claims, the dollar amount disallowed shall become a percentage of

the total paid on the sample, referred to as the exception rate. The audit exception rate found in the sampled claims reflects, from a statistical standpoint, the overall exception rate potentially possible within the universe of adjudicated claims for that fiscal year. This exception rate may be applied to the total universe of paid claims which will determine the final reimbursement due to the County.

If an audit of Physician or hospital records conducted by County and/or State representatives relating to the services for which claim was made and paid hereunder finds that (1) the records are incomplete or do not support the medical necessity for all or a portion of the services provided, or (2) no records exist to evidence the provision of all or a portion of the claimed services, or (3) Physician failed either to report or remit payments received from patients or third parties as required herein, or (4) the patient was ineligible for services hereunder, or (5) Physician did not otherwise qualify for reimbursement hereunder, Physician shall, upon receipt of County billing therefor, remit forthwith to the County the difference between the claim amount paid by the County and the amount of the adjusted billing as determined by the audit.

County also reserves the right to exclude Physician from reimbursement of future claims for any failure to satisfy conditions of this claiming process.

B. Indemnification/Insurance

By utilizing this claiming process, the Physician certifies that the services rendered by him/her, and for which claim is made, are covered under a program of professional liability insurance with a combined single-limit of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate.

By utilizing this claiming process, the Physician further certifies that his/her workers' compensation coverage is in an amount and form to meet all applicable requirements of the California Labor Code, and that it specifically covers all persons providing services on behalf of the Physician and all risks to such persons.

C. Non-discrimination

In utilizing this claiming process, the Physician signifies that he/she has not discriminated in the provision of services for which claim is made because of race, color, religion, national origin, ancestry, sex, age, physical or mental disability, or medical condition and has complied in this respect with all applicable non-discrimination requirements of Federal and State law.

XIV. COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND

ACCOUNTABILITY ACT OF 1996

The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ('HIPAA'). Contractor understands and agrees that, as a provider of medical treatment services, it is a 'covered entity' under HIPAA and, as such, has obligations with respect to the confidentiality, privacy, and security of patients' medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of its staff and the establishment of proper procedures for the release of such information, and the use of appropriate consents and authorizations specified under HIPAA.

The parties acknowledge their separate and independent obligations with respect to HIPAA, and that such obligations relate to transactions and code sets, privacy, and security. Contractor understands and agrees that it is separately and independently responsible for compliance with HIPAA in all these areas and that County has not undertaken any responsibility for compliance on Contractor's behalf. Contractor has not relied, and will not in any way rely, on County for legal advice or other representations with respect to Contractor's obligations under HIPAA, but will independently seek its own counsel and take the necessary measures to comply with the law and its implementing regulations.

CONTRACTOR AND COUNTY UNDERSTAND AND AGREE THAT EACH IS INDEPENDENTLY RESPONSIBLE FOR HIPAA COMPLIANCE AND AGREE TO TAKE ALL NECESSARY AND REASONABLE ACTIONS TO COMPLY WITH THE REQUIREMENTS OF THE HIPAA LAW AND IMPLEMENTING REGULATIONS RELATED TO TRANSACTIONS AND CODE SET, PRIVACY, AND SECURITY.

EACH PARTY FURTHER AGREES TO INDEMNIFY AND HOLD HARMLESS THE OTHER PARTY (INCLUDING THEIR OFFICERS, EMPLOYEES, AND AGENTS), FOR ITS FAILURE TO COMPLY WITH HIPAA.

IER:06/25/07

ATTACHMENT B-5

COUNTY OF LOS ANGELES ¥ DEPARTMENT OF HEALTH SERVICES

PHYSICIAN SERVICES FOR INDIGENTS PROGRAM – **METROCARE**
ST. VINCENT and ST. FRANCIS
PHYSICIAN REIMBURSEMENT POLICIES

Effective Upon Board of Supervisors' Approval Through November 30, 2007

I. POLICY STATEMENT

THE PURPOSE OF THIS POLICY IS TO ENSURE THE COUNTY'S CONFORMANCE WITH STATUTORY AND REGULATORY REQUIREMENTS, AND TO ADDRESS PRIORITIES OF THE HEALTH CARE SYSTEM WHICH ARE CRITICAL TO PROVIDING FOR THE MEDICAL NEEDS OF THE INDIGENT POPULATION IN THE COUNTY'S METROCARE PROGRAM.

II. GENERAL RULES

A. MetroCare Fee Schedule: The County utilizes the most current Physicians' Current Procedural Terminology ("CPT-4") codes which coincides with the current Resource Based Relative Values Scale ("RBRVS") unit values and pays at 100% of Medicare allowable Area 18 fee schedule to include patient copayment amount of twenty percent (20%), not to exceed billed charges. Reimbursement is also limited to the policy parameters contained herein.

B. Eligible Period: Reimbursement shall be for emergency, inpatient, and limited outpatient (one [1] followup visit) medical services through acute hospitalization and one (1) outpatient visit authorized by the County.

C. Exclusions:

1. Procedures which are not covered under Medicare are excluded from reimbursement.

2. Claims determined to be third party eligible, including Full Scope Medi-Cal and Medicare, will be denied. Claims for patients with Limited Scope Medi-Cal will be restricted to services not covered by Medi-Cal.

D. Assistant Surgeons: Reimbursement for assistant surgeons will be at a rate of 20% of the primary surgeon's fee (as per Medicare allowable fee schedule to include patient copayment amount of twenty percent [20%]).

E. Multiple Surgery Procedure Codes: Adjudication of claims involving multiple surgery procedure codes performed in an inpatient operating room requires submission of operative reports. The Procedure Codes

shall be paid as follows: 100% for 1st procedure, 50% for the 2nd through the 4th procedures, and the remaining to be paid upon review of the operative reports.

F. Nurse Practitioner and Physician's Assistant Services: Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician's assistants in California.

G. Office Visits: Physicians will be reimbursed for one post-discharge Medicare eligible office visit, if medically necessary as authorized by the County.

III. INELIGIBLE CLAIMS

A. Duplicate Procedures: Claims which include duplicate procedures provided to the same patient for the same episode of care are generally excluded from reimbursement except as otherwise authorized by Medicare. This does not apply for Evaluation & Management codes billed by separate physicians.

B. Unlisted Procedures: Procedures which are not paid by Medicare are excluded from reimbursement.

C. Non-physician Procedures: Procedures commonly not performed by a physician will be denied (e.g., venipuncture).

D. Insurance Rejections: Claims for patients with potential insurance or other third-party payer coverage will be denied unless a notice of rejection from the insurance company or other third-party payer is provided to the County. The rejection notice should indicate either (1) the patient is not a covered beneficiary or (2) the term of coverage expired prior to the date of the claimed service. If insurance or other third-party coverage has been denied for other reasons, e.g., the deductible has not been met, the type or scope of service has been classified as a nonemergency, or other similar issues denying insurance coverage, the claim will be denied. Where limited insurance policies have been exhausted by hospital billings, physician claims will be reviewed and considered on appeal.

IV. EXCLUSIONS

A. Radiology/Nuclear Medicine: Reimbursement for radiology codes will be limited to those appropriate to the differential diagnosis for the patient in the emergency department or inpatient setting.

B. EKGs: Reimbursement for EKG codes will be limited to those appropriate to the differential diagnosis for the patient in the emergency department or inpatient setting.

C. Pathology: Reimbursement for pathology codes will be limited to those codes eligible by Medicare.

D. Anesthesia: There are no exclusions as long as the procedure is billed per American Society of Anesthesiologists (ASA) codes.

V. ADDITIONAL EXCLUSIONS

Upon approval of the Board of Supervisors, the County may revise the Physician Reimbursement Polices from time to time as necessary or appropriate.

VI. APPEALS

At the full discretion and authorization of the County, appeals for claims rejected or denied may be submitted to the Physician Reimbursement Advisory Committee ("PRAC"), a committee of physicians selected by Hospital Council of Southern California and by the Los Angeles County Medical Association. Any determination by PRAC shall be advisory and for consideration by the County. Appeals shall include the HCFA-1500, operative reports, if applicable, and supporting documents as needed. Appeals shall be mailed to the contracted Claims Adjudicator

Appeals for claims rejected or denied may be submitted to the Physician Reimbursement Advisory Committee ("PRAC"), a committee of physicians selected by Hospital Council of Southern California and by the Los Angeles County Medical Association. Appeals shall include the HCFA-1500, operative reports, if applicable, and supporting documents as needed. Appeals shall be mailed to the contracted Claims Adjudicator:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
ATTN: APPEALS UNIT - METROCARE

IER:06/25/07